

MARYLAND DEPARTMENT OF HUMAN RESOURCES
 Family Investment Administration
Long Term Care Medical Assistance
Request for Information to Verify Eligibility

Local Department: Address:	Date:
	Case Name:
	Address:
	CID#: (Please use this number on all correspondence)
	Case Manager:
Telephone Number:	

Ms. /Mr. _____ for _____

After you give us a signed application, we have 30 days to make a decision about eligibility for Long Term Care Medical Assistance. To make that decision, we must have the verifications checked **NEED**. Please mail or bring them to our office at the address above by _____.
 Questions? Call your case manager at the number above.

Key: N/A – Not Applicable OK – Already have or do not need **NEED – Please provide**

I. BASIC REQUIREMENTS

- | N/A | OK | NEED | |
|--------------------------|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Signed, dated application (DHR/FIA CARES 9709) |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Face-to-Face interview |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Consent to Release Information - Nursing home to DSS worker (DES 2002 form) |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Consent to Release Information – DSS worker to nursing home (DES 2005 form) |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Voter Registration Form 784 |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | DHMH 257 (Medical certification initiated by Nursing Home) |

II. DEMOGRAPHIC DATA

- | N/A | OK | NEED | |
|--------------------------|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Proof of Social Security Number (SSA 1099, SSA letter, or other SSA verification) |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Medicare card |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Alien status (alien registration card, passport) |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Proof of disability (DHMH 4204, DHR/FIA 402B, DHR/FIA 161 - for applicants 21-64 years old who have not been determined blind or disabled by the U.S. Social Security Administration) |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Marriage Certificate/Divorce decrees |

III. MONTHLY INCOME

- | N/A | OK | NEED | |
|--------------------------|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Social Security Benefits (award letter, 1-800-772-1213) |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Private Pension (gross benefit/deductions, if any) |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Application for any private/public benefit which the applicant may be entitled |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Other (annuities, alimony, royalties, income from loans, etc.) _____ |

(PLEASE GO TO PAGE 2)

Case Name:	CID#:
------------	-------

IV. ASSETS

Checking, Savings, Certificate of Deposits, Stock, Bonds, Mutual Funds, Trusts, LTC Insurance, etc.
(for the month of application and any additional statements specified)

N/A	OK	NEED	NAME	ACCT. #	COMMENTS (which months, etc.)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____

Closed Accounts – final statement (accounts which were active/open at any time in the past 36 months)

N/A	OK	NEED	TYPE	ACCT. #	COMMENTS
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____

Life Insurance - Form DES 2001, letter from the Insurance Company (stating original face value, current cash value, dividend value, loans against policy), **or copy of policy with amortization table** for current cash value

N/A	OK	NEED	<u>Company Name</u>	<u>Policy Number</u>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____

Home Property/Other Property

N/A	OK	NEED	Primary/other: _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Mortgage Agreement <input type="checkbox"/> DHMH 4245 Physician’s Report <input type="checkbox"/> Deed(s)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> State Property Tax Assessment <input type="checkbox"/> DHMH 4255 Statement of Intent

Funeral Arrangements

N/A	OK	NEED	Bank Account Statements / Irrevocable and Itemized Contracts: _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

V. ALLOWANCES

Health Insurance

N/A	OK	NEED	Other Health Insurance (ID card – front and back, actual premium bill or cancelled check)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

Residential Allowance

N/A	OK	NEED	DHMH 4245 Physician’s Report
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

Spousal Allowance

N/A	OK	NEED	Income and Expense Reporting Form for Community Spouse
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

ADDITIONAL INFORMATION NEEDED (see attachment)

When I sign below it means I understand I must provide the information and verifications checked on this form. I may have to provide additional documentation, if indicated in the review of the material I provide. I understand this application is good for only six months from the date I applied and I will have to file a new application if I do not provide all required verification in that time period.

SIGNATURE